Testimony Regarding H.B. 5411, An Act Concerning Medicaid

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BACKGROUND

Currently, at least 18.7 percent of women smoke in Connecticut.[1] At least 10 percent are smoking during pregnancy. Because women who smoke during pregnancy are more likely than nonsmokers to have a preterm infant, the March of Dimes supports coverage of effective tobacco cessation methods for women of childbearing age, especially those who are pregnant. Smoking cessation services for pregnant women are among the handful of interventions that save enough in later medical expenses to offset the initial investment, and actually result in cost savings. Studies suggest that every $1 spent on smoking cessation counseling for pregnant women could save about $3 in reduced neonatal intensive care costs.[2]

Due to concern regarding the potential impact of tobacco cessation pharmaceuticals on a developing fetus, the American College of Obstetricians and Gynecologists (ACOG) recommends that providers refer pregnant smokers to tobacco cessation counseling in most cases, and that cessation pharmaceuticals primarily be used only for very heavy smokers and women for whom counseling has been ineffective. However, programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP) should reimburse for counseling as well as pharmaceuticals to ensure that the physician and woman have access to both intervention

STATE MEDICAID COVERAGE

Pregnant women who rely on Medicaid for their health insurance are more likely than other pregnant women to smoke, according to state data collected by the Centers for Disease Control and Prevention. While Medicaid programs in 42 states reimburse for some form of tobacco cessation intervention for pregnant women, 22 states do not cover counseling—the treatment of choice for pregnant smokers.

MARCH OF DIMES POLICY:

The March of Dimes urges pregnant women to stop smoking to improve pregnancy outcomes, prevent infant mortality, and protect their own health. The March of Dimes supports legislation and regulatory action to reduce exposure to tobacco smoke by women of child bearing age (especially those who are pregnant) and infants, and to increase the availability and access to effective smoking prevention and cessation services. The March of Dimes supports and advocates for states to include smoking cessation programs as part of maternity care.

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[1] March of Dimes 2009 Prematurity Birth Report Card, available at www.marchofdimes.com
[2] See Ayadi M.F., et al.. 2006 Costs of Smoking Cessation Counseling Intervention for Pregnant Women: Comparison of Three Settings. *Public Health Reports* 121:120-6.

THE PROBLEM:

In Connecticut, smoking cessation (pharmaceuticals and/or counseling) is not a covered treatment in the Medicaid state plan.

RECOMMENDATION:

The March of Dimes recommends an amendment to general statue (17b-278a) to require that smoking cessation treatment be included in Medicaid state plan.

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Support Medicaid Coverage of Tobacco Cessation for Pregnant Women

Smoking has been found to cause numerous health problems for women of childbearing age, and smoking during pregnancy has been linked to many poor birth outcomes, including preterm birth and low birthweight. Tobacco cessation counseling and pharmacological interventions have been found to save money, help women quit smoking, and improve birth outcomes. Unfortunately, some of the women who most need access to these services, lack health coverage for them. Ensuring that all pregnant women who rely on Medicaid have coverage for tobacco cessation counseling and pharmacotherapies can significantly increase the number of pregnant smokers who have access to effective cessation interventions.

Smoking During Pregnancy

- Women who smoke during pregnancy are more likely than nonsmokers to have a low birthweight or preterm baby.[1]
- Conservative estimates indicate that at least one out of every ten pregnant women smoke, accounting for half a million births per year.[2]
- According to a 2004 Surgeon General's report, "Health Consequences of Smoking," infants of women who quit smoking by the end of the first trimester have weight and body measurements comparable to infants of nonsmokers.

Cost of Preterm Birth and Low Birthweight

- According to a 2006 report by the Institute of Medicine, the annual societal economic cost (medical, educational, and lost productivity) associated with preterm birth in the US was at least $26.2 billion.
- The average first year medical costs are about 10 times greater for preterm ($32,325) than for term infants ($3,325).

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[1] Shah, NR and MB Bracken. 2000. "A Systematic Review and Meta-analysis of Prospective Studies on the Association Between Maternal Cigarette Smoking and Preterm Delivery." *American Journal of Obstetrics and Gynecology* 182(2):465-72.

[2] See, e.g., Markovic, R., et al., "Substance Use Measures Among Women in Early Pregnancy," American Journal of Obstetrics & Gynecology 183:627-32 (September 2000).

- Low birthweight accounts for 10% of all healthcare costs for children.

Smoking and Medicaid

- Pregnant women on Medicaid are 2.5 times more likely than other pregnant women to smoke, according to Medicaid data collected by the Centers for Disease Control and Prevention (CDC).
- According to joint estimates by the CDC and the Centers for Medicare and Medicaid Services, smoking-attributable neonatal health care costs for Medicaid total almost $228 million, or about $738 per pregnant smoker.
- Thirty-nine state Medicaid programs cover tobacco cessation pharmacotherapies (gum, patch, etc.) and 26 cover tobacco cessation counseling.
- Counseling is typically the first treatment recommended to pregnant smokers, but for very heavy smokers, providers may choose to prescribe pharmacotherapy in addition to counseling.

Tobacco Cessation Effectiveness and Cost Savings

- ***Studies suggest that every $1 spent on smoking cessation counseling for pregnant women could save about $3 in neonatal intensive care costs.***[3]
- In a managed care setting, a comprehensive smoking cessation benefit (counseling and pharmacotherapy) costs less than $5.92 per member per year (about $0.40 per month).[4]
- Prenatal smoking cessation programs have been shown to have a protective effect on intrauterine growth retardation.[5]
- A study in the July 2001 *American Journal of Preventive Medicine* ranked the effectiveness of various clinical preventive services recommended by the U.S. Preventive Services Task Force, using a one to ten scale, with ten being the highest possible score. Of the thirty preventive services evaluated, tobacco cessation ranked second in its degree of effectiveness, scoring a nine out of 10 (the highest ranking was for childhood vaccines which scored a 10). Among other preventive services covered by Medicaid, colorectal cancer screening received a score of eight and mammography screening scored a six.
- In 2006, a National Institutes of Health (NIH) state-of-the-science panel found that tobacco cessation interventions could double or triple quit rates if more smokers had access to them. The panel found that smoking cessation interventions/treatments such as nicotine replacement therapy and counseling were individually effective, and even more effective in combination.

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[3] Ayadi, MF and others. 2006. "Costs of Smoking Cessation Counseling Intervention for Pregnant Women: Comparison of Three Settings." *Public Health Reports* 121: 120-26.

[4] Curry SJ, Grothaus LC, McAfee T, Pabniniak C. Use and cost effectiveness of smokingcessation services under four insurance plans in a health maintenance organization.

[5] Ershoff DH,Quinn VP, Mullen PD, et al. Pregnancy and medical cost outcomes of a selfhelp prenatal smoking cessation program in a HMO. Public Health Reports 1990; 105(4):340-7.

March of Dimes 2009 Premature Birth Report Card

The March of Dimes graded states by comparing each state's rate of premature birth to the nation's objective of 7.6 percent or less by 2010. This year we are also awarding a star when the rate for one of the selected contributing factors (below) is moving in the right direction. We don't yet understand all the factors that contribute to premature birth. The nation must continue to make progress on research to identify causes and prevention strategies, improve the outcomes of preterm infants, and better define and track the problem.

Grade for Connecticut

Preterm Birth Rate: **10.5%**

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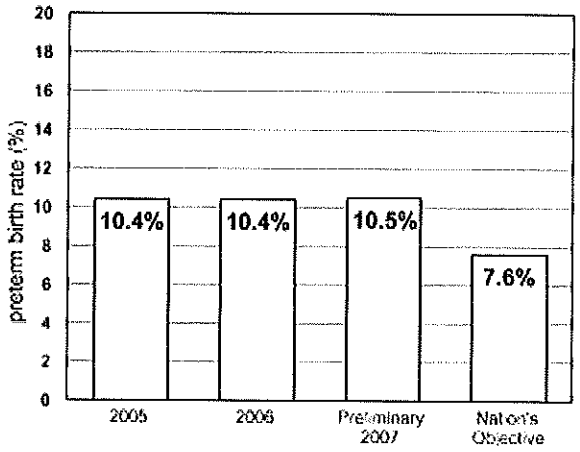

Status of Selected Contributing Factors

Factor	Previous Rate	Latest Rate	Status	Recommendation
Uninsured Women	13.5%	12.2%	★	Health care before and during pregnancy can help identify and manage conditions that contribute to premature birth. We urge federal and state policymakers to expand access to health coverage for women of childbearing age, and we urge employers to create workplaces that support maternal and infant health.
Women Smoking	16.7%	18.7%	X	Smoking cessation programs can reduce the risk of premature birth. We urge federal and state support of smoking cessation as part of maternity care.
Late Preterm Birth	7.1%	7.2%	X	The rise in late preterm births (34-36 weeks) has been linked to rising rates of early induction of labor and c-sections. We call on hospitals and health care professionals to voluntarily assess c-sections and inductions that occur prior to 39 weeks gestation to ensure consistency with professional guidelines.

★ = moving in the right direction n/c = no change X = moving in the wrong direction

State Actions:

For information on how we are working to reduce premature birth, contact the March of Dimes Connecticut Chapter at (860) 812-0080.

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March of Dimes 2009 Premature Birth Report Card Technical Notes

Data Sources and Notes

All calculations were conducted by the March of Dimes Perinatal Data Center.

		Data Sources	
Indicator	Definition	50 states and D.C.	Puerto Rico
Preterm birth (percent)	Percentage of all live births less than 37 completed weeks gestation	National Center for Health Statistics (NCHS), 2007 preliminary, 2006 and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary, 2006 and 2005 final birth data
Late preterm birth (percent)	Percentage of all live births between 34 and 36 weeks gestation	NCHS, 2007 preliminary and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary and 2005 final birth data
Uninsured women (percent)	Percentage of women ages 15 to 44 with no source of health insurance coverage	U.S. Census Bureau, Current Population Survey, 2007 to 2009 and 2006 to 2008	Percentage of women ages 18-44 with no health care coverage, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2008 and 2007 data
Women smoking (percent)	Percentage of women ages 18 to 44 who currently smoke either every day or some days and who have smoked at least 100 cigarettes in their lifetime	CDC, BRFSS, 2008 and 2007 data	CDC, BRFSS, 2008 and 2007 data

Where possible, national data sources were used so that data is consistent for each state and jurisdiction-specific premature birth report card. Therefore, data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies. This could be due to multiple causes. For example, as part of the Vital Statistics Cooperative Program, states are required to send NCHS natality and mortality data for a given year by a specific date. Sometimes states receive data after this date, which may result in slight differences in the rates calculated using NCHS-processed data and state-processed data. Another reason preterm birth rates, in particular, may vary is due to differences in the way NCHS and the states calculate variables and impute missing data. Collaboration among March of Dimes chapters, state and local health departments and other local partners, will provide a deeper understanding of specific contributors to preterm birth. 2007 preliminary data are reported for the percentage of preterm birth and late preterm birth by state. Preliminary data are based on more than 99 percent of the births in 47 states, D.C. and Puerto Rico but are less complete for three states, Louisiana (91.4 percent), Georgia (86.4 percent) and Michigan (80.2 percent). 2007 final preterm and late preterm birth rates are expected to be very similar to the 2007 preliminary rates but may differ for these three states.

March of Dimes 2009 Premature Birth Report Card Technical Notes, continued

Grading Methodology

Premature birth report card grades are based solely on the distance of a state's rate of preterm birth from the nation's *Healthy People 2010* (HP) objective of 7.6 percent. The grading criteria established for 2008 report cards is used as a baseline and provides for annual preterm birth report card grade comparison. Each jurisdiction was assigned a grade based on the following criteria.

Grade	Preterm birth rate/Score criteria
A	Preterm birth rate less than or equal to 7.6 percent (HP score less than or equal to 0)
B	Preterm birth rate greater than 7.6 percent, but less than 9.4 percent (HP 2010 score greater than 0, but less than 1)
C	Preterm birth rate greater than or equal to 9.4 percent, but less than 11.3 percent (HP 2010 score greater than or equal to 1, but less than 2)
D	Preterm birth rate greater than or equal to 11.3 percent, but less than 13.2 percent (HP 2010 score greater than or equal to 2, but less than 3)
F	Preterm birth rate greater than or equal to 13.2 percent (HP 2010 score greater than or equal to 3)

To determine the above ranges, an "HP 2010 score" was calculated in 2008 using the following formula: (2005 preterm birth rate – HP 2010 objective) / standard deviation of 2005 state and D.C. preterm birth rates. Scores were rounded to one decimal place.

Selected Contributing Factors

The March of Dimes has identified and provided geographically-specific data for three selected contributing factors: uninsured women, women smoking and late preterm births. While these important and potentially modifiable factors represent prevention opportunities for consumers, health professionals, policymakers and employers, they do not represent an exhaustive list of contributors to preterm birth. With the momentum provided by the premature birth report card, states and jurisdictions may likely identify and take action to address other potentially modifiable contributors that play an important role in the prevention of preterm birth.

Status of Contributing Factors

Rates for all contributing factors are rounded to one decimal. Under the status column, changes in rates of contributing factors between the baseline and current year are designated with a star, an X or n/c. A star signifying movement in the right direction indicates a decline in the rates of contributing factors. An X signifying movement in the wrong direction indicates an increase in the rates of contributing factors. No change between the baseline and current year is designated with n/c.